

**Suspected Fraudulent Claim (SFC)
Referral Form (FD-1)****CDI USE ONLY**

Case #: _____ County Code: _____ SFC #: _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER ☐

REPORTING REQUIREMENTS: Please print legibly or type. California Insurance Code (CIC) § 1872.4 requires companies licensed to write insurance in California to submit this form **WITHIN 60 DAYS** after determining that a claim appears to be fraudulent. CIC § 1877.3 further requires reporting of suspected fraudulent Workers' Compensation claims to **BOTH** the CDI Fraud Division and the local District Attorney's Office **WITHIN 30 DAYS**.

SECTION I. REPORTING PARTY INFORMATION CODEFRAUD TYPE CODE: _____ REPORTING PARTY CODE: _____ CHECK ONE: ☐ NEW REFERRAL ☐ AMENDED REFERRALREPORTING PARTY: _____
Company Name Certificate of Authority (CA)# Self-Insured/TPA#

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS (IF APPLICABLE): _____

SECTION II. LOSS/INJURY INFORMATIONALLEGED VICTIM: _____
Company Name Certificate of Authority (CA) # Self-Insured/TPA#

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CLAIM #: _____ POLICY #: _____ DATE OF LOSS/INJURY: ____ / ____ / ____

ADDRESS OR LOCATION WHERE LOSS / INJURY OCCURRED:

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

| | | | |
|-------------|-------------|----------------|---------------------|
| PREMIUM | POTENTIAL | ACTUAL PAID | SUSPECTED |
| LOSS: _____ | LOSS: _____ | TO DATE: _____ | FRAUDULENT |
| | | | LOSS TO DATE: _____ |

SECTION III. SUSPECTED FRAUDULENT CLAIM ACTIVITY

SYNOPSIS: State the facts (who, what, when, where, how, why) that support your suspicion of fraudulent claim activity including any material misrepresentation(s). Provide details regarding any prior history of fraudulent insurance claim activity by any of the parties. If known, include relevant claim numbers. Attach additional summary sheets if needed.

You may include attachments documenting the suspected fraudulent activity. If a complete copy of the claim file has been submitted to the District Attorney's Office, please attach a complete copy to this Form FD-1. Otherwise, a complete copy of your claim file is not required.

DISASTER CLAIMS: If this suspicious activity is related to a major natural or non-natural disaster, check the box below that best describes the related event:

☐ EARTHQUAKE ☐ FLOOD ☐ FIRESTORM ☐ WIND ☐ OTHER NATURAL ☐ NON-NATURAL (MAN-MADE)
SECTION IV. REPORTS TO OTHER AGENCIES☐ OTHER LAW ENFORCEMENT AGENCY (specify name): _____☐ DISTRICT ATTORNEY'S OFFICE (specify name): _____☐ NICB ☐ OTHER: _____**SECTION V. CONTACT INFORMATION**

CONTACT (name/title): _____ PHONE: () _____

FILE HANDLER (if different): _____ PHONE: () _____

COMPLETED BY (if different): _____ PHONE: () _____

DATE FORM
COMPLETED:

____ / ____ / ____

Mail completed forms to: CDI Fraud Division Intake Unit, P.O. Box 277320, Sacramento CA 95827-7320

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Parties to the Loss/Injury

Case #: _____ County Code: _____ SFC #: _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
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Claim #: _____ Policy #: _____ Date of Loss/Injury: ____ / ____ / ____

SECTION VI. INSURED/EMPLOYER INFORMATION (Party A)**PARTY A.** ☐ INSURED ☐ EMPLOYER (CHECK ONE/If Workers' Compensation, must show employer here.)Name: _____ Phone #: ____ (____) ____
Last Name First Name MI
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No**SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)****PARTY B.** ☐ (Enter party code in box)Name: _____ Phone #: ____ (____) ____
Last Name First Name MI
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No**PARTY C.** ☐ (Enter party code in box)Name: _____ Phone #: ____ (____) ____
Last Name First Name MI
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No**PARTY D.** ☐ (Enter party code in box)Name: _____ Phone #: ____ (____) ____
Last Name First Name MI
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No**PARTY E.** ☐ (Enter party code in box)Name: _____ Phone #: ____ (____) ____
Last Name First Name MI
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

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Parties to the Loss/Injury (continued)

Case #: _____ County Code: _____ SFC #: _____

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Claim #: _____ Policy #: _____ Date of Loss/Injury: ____ / ____ / ____

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)**PARTY .** ☐ (Enter party code in box)

Name: _____ Phone #: _____ ()

Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ (Enter party code in box)

Name: _____ Phone #: _____ ()

Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ (Enter party code in box)

Name: _____ Phone #: _____ ()

Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ (Enter party code in box)

Name: _____ Phone #: _____ ()

Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ (Enter party code in box)

Name: _____ Phone #: _____ ()

Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

If you need to report more parties to the loss, please complete and attach additional copies of this page as needed.